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АКТУАЛЬНІ ПИТАННЯ ВНУТРІШНЬОЇ МЕДИЦИНИ. ВІД КЛІНІЧНИХ ДОСЛІДЖЕНЬ ДО КЛІНІЧНОЇ ПРАКТИКИ

тези наукових доповідей
науково-практичної конференції

присвяченої
пам'яті академіка НАМН України Г.В. Дзяка

17–18 травня 2017 р.
м. Дніпро

Дніпро
«Герда» | 2017

Results. Echocardiographic parameters, 6 min walk test distance did not differ significantly between the groups (p=0,027). After 12 weeks of treatment with meldonium the incidence of exertion-related symptoms, including chest pain, dyspnoea, fatigue were significantly lower in the 1st in comparison with the 2nd groups (p=0,05). The distance of the 6 min walk test in 31 % pts have been increased in the 1st group by 26,47 % (p<0.01); in the 2nd group in 20 % pts – by 9,47 % (p<0,01). 6 min walk test correlated to NYHA functional class (r=0,25; p<0,05). After 12 weeks of treatment with meldonium the 1st group had significantly less stenotic progression, than the 2nd group (average decrease in AVA; 0,14 sm^2 versus 0.19 sm^2, respectively (p<0,05)).

Conclusion. Meldonium is effective and safe for the elderly pts with CHF and preserved ejection fraction and AS. Meldonium reduces progression of CHF and AS. Its administration may provide benefits for the reduction of hospitalizations and mortality in this category patients.

THE FEATURES OF ASYMPTOMATIC LEFT VENTRCAL DYSFUNCTION IN PATIENTS WITH IHD COMBINED WITH COPD

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Background. According to ESC guidelines 2016 for the diagnosis and treatment of heart failure, a patient who has never exhibited the typical symptoms and/or signs of heart failure (HF) and with a reduced left ventrical (LV) ejection fraction (EF) is described as having asymptomatic LV systolic dysfunction (ALVD). The absence of clinical signs and symptoms of HF may reflect the delay in the process of diagnosis and therapy.

IHD is the most common comorbidity and the leading cause of hospitalization in patients with COPD. Indeed, numerous epidemiological studies have shown that COPD, independent of cigarette smoking and aging, doubles the risk of CVD hospitalization and death. To date, the mutual burdens of IHD and COPD have been proven. Left ventricular dysfunction in IHD aggravates the effects of COPD through impairment of pulmonary hemodynamics. The basis for unfavorable interaction of IHD and COPD is systolic and diastolic dysfunction of the left ventricle due to its hypertrophy, increased aortic stiffness, hypoxia effect, right ventrical dysfunction.

The aim of this study was to estimate of asymptomatic LVD in patients with IHD and COPD while in a stable condition.

Materials and methods: 45 patients were included in this study (male – 32 (71,1 %), female – 13 (28,9 %)). All patients had IHD combined with COPD, and had never exhibited the typical symptoms and/or signs of HF. Mean age was 60,0±10,01 years. Patients were divided into groups according to GOLD 2017. In the control group were included 20 patients with IHD without COPD, relevant by age, sex and severity,

respectively the main group. Physical examination, 12-leads ECG, ambulatory ECG (Holter) monitoring, 6-WT, echocardiography, spyrometry, pulsoxymetry, Nt -proBNP level detection were performed to all patients

Results. All patients had stable angina: class II– 34 patients (75,6 %),class III – 11 patients (24,4 %) according to the Canadian Cardiovascular Society. 32 patients had IHD assotieted with AH (71,1 %). Severity of COPD was assessed according to GOLD, 2017: group B – 29 patients (64,4 %), group C – 10 (22,2 %), group D – 6 (13,4 %). Severity of airflow limitation was mild (FEV1 ≥80 % predicted) in 3 patients (6,7 %), moderate (50 %≤FEV1<80 % predicted) – 31 (68,9 %), severe (30 %≤FEV1<50 % predicted) – 11 (24,4 %)

We assessed LVEF for diagnosis of ALVD. 29 patients (64,4 %) had LVEF 49–41 % (mid-range EF), 11(35,6 %) – 54–50 % (preserved EF). 12 (60,0 %) patients without COPD had LVEF 49–40 %, 8 (40,0 %) – less than 40 % (reduced EF).

Nt -proBNP level detection was performed. Mean level of Nt -proBNP in patients with IHD and COPD was 674,2±56,1 pg/ml. This is the so-called «gray zone». In patients without COPD ean level of Nt -proBNP was in within reference ranges.

We examined left ventrical geometry according to recommendations of European Association of Cardiovascular Imaging (EACVI) and the American Society of Echocardiography (ASE) 2015. Mean range of RWT was 0,44±0,129, LVM index – 79,3±13.76 g/m^2, LVM – 139.5±24,48 g, LVV – 103,4±9,07 mL, LV volume index, 58,4±7,49 mL/m^2. The value of the ejection fraction correlates with the type of remodeling of LV. EF≥50 % relevant concentric remodeling of LV. Concentric remedeling was also presented in 79,3 % cases EF 41–49 % (23 patients among 29). In patients without COPD, the eccentric type of remodeling predominated.

Conclusions. In patients with IHD combined with COPD, ALVD predominates with a preserved or mid-range EF, based on concentric LV remodeling. In our opinion, the definition of ALVD in such patients should include not only a reduced, but also mid-range and preserved EF, since this will determine the direction of treatment.

THE GENERAL CHARACTERISTICS OF THE T- AND B-CELL IMMUNITY, DEPENDING ON THE BODY MASS INDEX IN THE PATIENTS WITH THE NONALCOHOLIC FATTY LIVER DISEASE IN COMBINATION WITH THE OBESITY

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In recent years, the role of the liver as one of the major organs of the immune system has been widely recognized due to the population of macrophages and killer cells it contains. They are components of the innate immune system. However, the immune response in case of non-alcoholic fatty liver disease (NAFLD) with concomitant obesity (OB) is insufficiently studied; in the literature there some data about changes in the liver innate immunity and the role of acquired immunity in the progression of NAFLD.